

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

CERTIFICATE OF DEATH

11152

Reg. Dist. No. 200

1. PLACE OF DEATH:

County KentCity or town Galena
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 mo

Hospital, institution, or street address where death occurred:

How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County KentCity or town Galena
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Justina Haley Buck

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

James H. Buck

7. Birth date of

deceased (mo., day, yr.)

Nov. 11, 1883

8. AGE:

67 years 4 months 4 days If less than one day

9. Birthplace

Cecil Co. Md.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

None

MOTHER

FATHER

12. Name

Alfred J. McBurn

13. Birthplace

Cecil Co. Md.

14. Maiden name

Anna Webb

15. Birthplace

Cecil Co. Md.

16. Informant

James H. Buck

Address

Galena, Md.

17. Burial

Nov 19/45

(Burial, cremation, or removal. Which?)

Galena

Cemetery or crematory

Galena, Md.

Location

Edmund Taylor

18. Funeral director

Mulholland

Address

Mulholland

19. Nov. 19

1945

E. J. Dimech

Local

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 18 1945 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

Nov 18 1945 to Nov 18 1945and that I am a duly licensed physician in the State of MarylandImmediate cause of death Coronary artery disease

RECEIVED

NOV 21 1945

SUBJECTIVE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 544

CERTIFICATE OF DEATH

11153

Reg. Dist. No. 201

1. PLACE OF DEATH:

County St. Louis
 City or town Still Pond md
 (If outside city or town limits, write RURAL NEAR and give town)
 Street address, hospital, or institution: _____

Stay in hospital or inst. (yrs., or mos., or days) _____
 Stay in this community (yrs., or mos., or days) 50 years

3. (a) FULL NAME

Charles Collins

4. Sex Male 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Elizabeth H. Collins6. (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) March 14 1880

8. AGE: Years 65 Months 37 Days 4 It less than one day _____ hrs. _____ min.

9. Birthplace Seyford Delaware
 (Town, county, and state)

10. Usual occupation Farm work11. Industry or business Farm12. Name Charles Collins13. Birthplace Delaware14. Maiden name Laura15. Birthplace Delaware16. Informant Elizabeth CollinsAddress Still Pond, md.

17. Burial Date thereof Nov 22 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory West ZionLocation Still Pond, md.18. Funeral director B. R. GellowsAddress Still Pond md.

19. 11-22 1945 J. Helack
 (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County 1 Cent
 City or town Still Pond md Ward No. _____
 (If outside city or town limits, write RURAL NEAR and give town)

Street No. _____
 (If rural give LOCATION)

2 (c) IF VETERAN, NAME WAR _____

3. (b) Social Security Number

213-18-4354

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 18 1945, at 8:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1945, to Nov 18 1945,
 and that I last saw him alive on Nov 18 1945.

Immediate cause of death

Causes of Probable
chron. Endo-Myo, or arthritis
neuritis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline
 the cause to which
 death should be
 charged statisti-
 cally.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

Albert A. Burgard
Rock Hall, Md.

M. D. or other _____

Address _____ Date signed 11/20/45

11121

CERTIFICATE OF DEATH

RECORDED
NOV 26 1945
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(92d)

CERTIFICATE OF DEATH

11154

Reg. Dist. No. 203

1. PLACE OF DEATH:

County Kent
 City or town Rock Hall Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent
 City or town Rock Hall Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Seneca St
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Samuel A. Dawson

3. (b) Social Security Number

4. Sex male 5. Color or race Wh. 6.(a) Single, married, widowed, or divorced widowed
 6.(b) Name of husband or wife Elizabeth Dawson
 7. Birth date of deceased (mo., day, yr.) June 1 1860 6.(c) If alive, give age _____ years
 8. AGE: Years 85 Months 5 Days 8 If less than one day _____ hrs. _____ min.

9. Birthplace Kentucky
 (Town, county, and state)
 10. Usual occupation retired
 11. Industry or business Railroad
 FATHER 12. Name not known
 13. Birthplace —
 MOTHER 14. Maiden name not known
 15. Birthplace —

16. Informant Mrs Willard Taylor
 Address Rock Hall, Md
 17. Burial Date thereof Nov 10 - 45
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Wesley Chapel
 Location Rock Hall, Md
 18. Funeral director Edgar L. Lane
 Address Church Hill
 19. Nov 10 19 45 S. Elwood Bingham
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8 19 45 at 2:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19 45, to Nov 8 19 45
 and that I last saw him alive on Nov 8 19 45

Immediate cause of death cardiac failure
chron. Endo - myocarditis
 Due to decompensation
 Due to hypertension
 Other conditions —
 (Include pregnancy within 3 months of death)

Major findings of operations —
 Date of op. —
 Autopsy results —
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide — Date of —
 Where did injury occur? — (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) —
 Means of injury — Injured at work? —

23. SIGNATURE Albert A. BURGARD M. D. or other
Rock Hall, Md Address Date signed 11/8/45

RECEIVED

NOV 16 1945

BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1642

CERTIFICATE OF DEATH

11155

Reg. Dist. No. 208

1. PLACE OF DEATH:

County Kent
 City or town Park Hall
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? life
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Kent
 City or town Park Hall
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2(a) If veteran, name war _____

3. (a) FULL NAME

Charles Edward Hudson

3. (b) Social Security Number

218-16-6513

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Mary Louisa Hudson
 6. (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) August 11 1893

8. AGE: Years 52 Months 2 Days 29 If less than one day _____ hrs. _____ min.

9. Birthplace Park Hall Kent Co. Md.
 (Town, county, and state)

10. Usual occupation laborer

11. Industry or business Carpenter

12. Name Chas. Henry Hudson

13. Birthplace Park Hall, Maryland

14. Maternal name Emma Crouch

15. Birthplace Park Hall Maryland

16. Informant Mr. Wm. Thos. Hudson (Brother)

Address Park Hall, Maryland

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Nov. 11, 1945
 (month) (day) (year)

Cemetery or crematory Wesley Chapel

Location Park Hall, Maryland

18. Funeral director Marion V. Williams

Address Chattahoochee, Maryland

19. 11/10 19 45 S. Elwood Burgess
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8 19 45 at 8:00 P. M.

21. I CERTIFY that death occurred on the date above stated, that it preceded recovery from any illness or injury, and that it was not due to any of the following causes:
Brain, Spinal Cord, Heart, Lungs, Kidneys, Liver, Stomach, Intestines, Blood Vessels, Bones, Muscles, Nerves, Glands, Skin, or any other organ or system.

Immediate cause of death Gunshot wound DURATION _____

Due to Head

Due to Suicide

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. _____

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes fill in the following:

Accident, suicide, or homicide Suicide Date of Nov 8/45

Where did injury occur? Park Hall Kent (City or town) MD (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Revolver Injured at work? No

23. SIGNATURE Dr. J. H. Williams M. D. or other _____

Address Chattahoochee, Md. Date signed Nov 9/45

RECEIVED
NOV 16 1945
BUREAU V. R.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11156

Reg. Dist. No. 202

1. PLACE OF DEATH:

County KentCity or town Chestertown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 33 years

Hospital, institution, or street address where death occurred:

115 Water Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County KENTCity or town CHESTERTOWN
(If outside city or town limits, write RURAL and give nearest town)Street No. WATER ST

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Henry Augustus Keatley4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Gertrude R. Keatley7. Birth date of deceased (mo., day, yr.) 4-25-1848 8.(c) If alive, give age 77 years8. AGE: Years 77 Months 7 Days 2 If less than one day9. Birthplace Chester Co., Pennsylvania
(Town, county, and state)10. Usual occupation Retired

11. Industry or business

12. Name Christopher Keatley13. Birthplace Chester Co., Pennsylvania14. Maiden name Mary Feltz15. Birthplace Pennsylvania16. Informant Richard C. BarnesAddress Chestertown, Md.17. Burial Date thereof 11-28-1945
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory ChestertownLocation Chestertown, Maryland18. Funeral director J. H. H. HallAddress Chestertown, Md.19. Nov. 28, 1945 Clara S. Barnes
(Date rec'd by registrar) Registrar

3.(b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7, 1945 at 5 P M21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Nov. 20 to Nov 27 1945and that I last saw him alive on Nov 28 1945Immediate cause of death MyocarditisDuo to Ischemic Disease

Duo to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date ofWhere did injury occur? none
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury none Injured at work?23. SIGNATURE Frank Jones M. D. or otherDate signed Nov 7/45

RECEIVED
NOV 30 1945
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11157 203 5003

1. PLACE OF DEATH:

County Kent
 City or town Rock Hall Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? same 1940
 Hospital, institution, or street address where death occurred: -
 How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent
 City or town Rock Hall Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Senneberg
 (If rural, give LOCATION)
 2.(a) If veteran, name war -

3. (a) FULL NAME

Samuel Lee Magness

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

maleW.married6. (b) Name of husband or wife Stella F. Magness6. (c) If alive, give age 63 years7. Birth date of deceased (mo., day, yr.) Dec 27 18778. AGE: Years Months Days If less than one day
67 10 26 - hrs. - min.9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual occupation Physician (retired)11. Industry or business -12. Name Samuel L. Magness13. Birthplace Baltimore, Md.14. Maiden name Mary P. Chaney15. Birthplace Baltimore16. Informant Mrs. Stella F. MagnessAddress Rock Hall, Md.17. BURIAL Date thereof Nov. 26, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory LORRAINE CEMETERYLocation BALTIMORE, COUNTY18. Funeral director WILLIS WELLSAddress CHESTERTOWN, MARYLAND19. 11/23 45 S. Elwood Burgess
(Date rec'd by registrar) (Year) (Month) (Day) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22 19 45, at 3:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Kent 19 42, to Nov 22 19 45
and that I last saw him alive on Nov 22 19 45

Immediate cause of death

acute cardiac failure
due to atherosclerosis

DURATION

Due to Arterial accident (42)Due to Hypertension ParalysisOther conditions arteriosclerosis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. -

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -Where did injury occur? - (City or town) (County) (State)Injured at home, farm, industry, public place (where?) -Means of injury - Injured at work? -23. SIGNATURE Albert A. Burgard M. D. or other
Rock Hall, Md.
Address - Date signed 11/22/45

RECEIVED
NOV 26 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 19106

CERTIFICATE OF DEATH

11158

Reg. Dist. No. 203

1. PLACE OF DEATH:

County Kent
 City or town Rock Hall
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 years
 Hospital, institution, or street address where death occurred: -
 How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent
 City or town Rock Hall
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Sharp St
 (If rural, give LOCATION)
 2.(a) If veteran, name war -

3. (a) FULL NAME

Alouzo Travers

3. (b) Social Security Number

4. Sex Male 5. Color or race Wh. 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Pora Travers
 6.(c) If alive, give age 57 years
 7. Birth date of deceased (mo., day, yr.) Nov 9th 1872
 8. AGE: Years 73 Months 0 Days 9 If less than one day - hrs. - min.

9. Birthplace Hoopers Island Md
 (Town, county, and state)
 10. Usual occupation Retired Preacher
 11. Industry or business -

FATHER 12. Name Benjamin Travers
 13. Birthplace Hoopers Island Md
 MOTHER 14. Maiden name Bernice Creighton
 15. Birthplace Hoopers Island Md

16. Informant Wm. Frank M. Vetter
 Address Rock Hall, Md

17. Burial Date thereof 11-20-45
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory St Paul's
 Location near - in Chestertown

18. Funeral director James H. Cemetery
 Address Chestertown Md

19. 11/19 19 45 S. Elwood Burgess
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18, 1945 at 1240A M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 14 19 45 to Nov 18 19 45
 and that I last saw him alive on Nov 17 19 45

Immediate cause of death Cerebral accident
chronic - myocardial dis
 Due to Hypertension
chronic nephritis
 Due to uremia
 Other conditions enlargement of prostate
 (Include pregnancy within 3 months of death)

Major findings of operations prostatectomy
 Date of op. 1943

Autopsy results -
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide - Date of -
 Where did injury occur? - (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) -
 Means of injury - Injured at work? -

23. SIGNATURE Albert A. Burgard M. D. or other
Rock Hall, Md Date signed 11/18/45
 Address -

RIE

NOV 23 1945

BUREAU